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RHODE ISLAND CASH SICKNESS COMPENSATION ACT

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Our much honored President has asked me to talk on the Rhode Island Cash Sickness Compensation Act. But to view this Act in its proper relation to the trend of other social legislation in this country and abroad it must be presented with a background of past and contemporary legislation in the same field.

We are, of course, most interested in the part medicine will be and is expected to play in this world of rapidly changing social relations. The State is taking on a greater control. We are being hemmed in more and more and the rights heretofore considered inalienable, promise to be taken away. The change has come rapidly too. Do you realize that it was not until 1892 that the State of Rhode Island began exercising any control of the practice of medicine? Before that time anyone with temerity to write "Doctor" before his name could practice on a gullible and unsuspecting public.

In the Rider Collection in the John Hay Library there is the reprint of an address delivered before this august body in June 1889 by Dr. George L. Collins, a man many of us remember, in which the writer decries the fact that the State was doing so little at that time to protect its citizens from the host of charlatans and illy trained so-called doctors that had reduced the practice of medicine in Rhode Island to the lowest ebb. Dr. Collins, of course, lived to see the State take the control it rightfully should, but I doubt if he in his generation ever dreamed that the pendulum would swing so far.

This whole movement for social betterment apparently stems from two sources. First the gradual increase in comfortable living has made the more fortunate ones more alive to the struggles of those less fortunate. In other words the whole world has become more humanitarian and in becoming so, various schemes have been proposed to lighten the lot of the poorer part of the population. The second factor has been the increasing insistent cry of labor for a larger share of the fruits of its labors. And along with this a demand for greater security in time of sickness and unemployment.

In times past it may have been verbally acknowledged that "the laborer is worthy of his hire," but capital saw to it that the amount of hire was kept down to a figure that made him doubly worthy of the little he received! All this was changed when labor organized, and the more completely labor organized, the greater its bargaining power regarding working hours, the amount of its remuneration and its right to be considered in the social scheme.

Strangely enough though, in the early days of social reform in this country it was labor itself that opposed legislation intended for its special benefit. In 1915 a Bill was presented in Congress calling for a system of compulsory insurance that planned protection for workers in time of sickness or unemployment. Opposition to the Bill came largely from the workers themselves. And although several redrafts of the Bill were made to do away with obvious objections, the opposition was so strong and well entrenched that all hope of national legislation along social lines was abandoned by 1918.

It is rather surprising that such opposition should have developed, in view of the well known fact that several European countries already had well-tried systems of Social Insurance that seemed to be working satisfactorily. Germany introduced such a system in 1883. Her lead was quickly followed by several other countries and finally by England with the Medical Act of 1911.

It is well to bear in mind that all of these earlier Acts were aimed at benefiting members of low income groups alone, while more recent legislation tends to bring all citizens, no matter what their financial status, into one great insured group.

Certainly the United States has lagged behind all other nations in social legislation. We have for years adopted a laissez faire attitude that has let private relief agencies take care of the more unfortunate portion of our population from funds subscribed by kindly disposed individuals. This system seemed to work fairly well until the Great Depression of 1929 put such a load on the private agencies that they were by no means able to relieve the acute distress that developed. Government was obliged to step in and once in has proceeded to try out various social experiments proposed by a group popularly known as the "New Dealers". There is no doubt that the seriousness of the situation gave a real justification for forcing through much untried and more or less theoretical legislation.

It was inevitable that some of this legislation should directly affect the medical profession. For there had been much grumbling over the high cost of medical care, but never any concerted effort by either Legislators or the Medical Profession itself to bring definite medical care to that portion of the public that sorely needed it and was unable to pay for it except at great sacrifice. A belief had grown up that health was a commodity that could be bought. That to be well, all one needed was a few dollars in one's pocket to pay some doctor for what was most to be desired. Unfortunately this is true to a certain limited extent.

It is a sad commentary on the intelligence of any group, be it the American Medical Association or any other, to have them say, "There is no medical problem in this country." For all of us know only too well that we are individually and constantly seeing patients who are debarred from competent diagnosis and proper treatment from lack of funds.

By and large the high standards of the medical profession are without question. We are willing to and do sacrifice ourselves constantly for the good of our fellow men. But after all we too are laborers working for hire and cannot be expected to act more than just so often as angels of mercy and financial agents at the same time!

It would be useless and far beyond the scope of this paper to argue the rights of labor to dictate or even suggest methods of social reform to our central Government. But labor is so firmly in the saddle that mere suggestions are listened to as never before by ears to the ground in Washington. The resolutions passed at a recent meeting of C. I. O. asking for national legislation to expand the benefits of Social Security and a more recent one of the American Federation of Labor asking for exactly the same thing, may have a tremendous effect on our labor minded administration.

Like an answer to these very resolutions, comes a Bill before Congress by our own Senator, Theodore Francis Green, which has for its purpose quite a large expansion of benefits under Social Security. By a slight increase in the contributions now called for, our workers are to secure freedom from fear and freedom from want as part of our War Aims. Among many other benefits free hospitalization is to be provided and when necessary re-habilitation service by qualified practitioners in Governmental and non-Governmental hospitals. The Bill does not state where the "qualified" doctors are to come from, and how they are to be paid. Very likely Senator Green and others are looking forward to the time when the pendulum of social reform having swung far enough, they can put through a bill such as the one proposed very recently in Australia. There a National Health and Medical Service scheme is under consideration. Under it all existing hospitals and health services would be taken over by the Federal Government. Some four thousand salaried doctors would be appointed and they would work in 460 medical centers. Their salaries would range from 26 to 52 hundred dollars per year—rather small sums, when the average gross income of medical men in Australia is given as 6850 dollars!

All of these newly fledged schemes seem to use the war as an excuse for their birth. We can grant that this last and worst of all wars is in a manner a revolution. Certainly the world will be greatly changed when it is over. But I doubt if there is any thought in the minds of the men who are giving their all to rid the world of the menace of Naziism, that they are engaged also in a real revolution in the field of social relations. Perhaps the war is stimu-

lating this sort of change more than we think. I have read, for instance, that the very radical Beveridge Report has been received with signs of approval in England largely because the middle and upper classes there have learned more of misery among their less fortunate countrymen from the evacuation of children from the large centers of population, than they ever dreamed of. Their sympathies have been aroused and they are willing to accept any scheme however Utopian that promises betterment.

Of all plans thus far proposed the one outlined by Beveridge and his associates is the most all-embracing. It is embodied in the report of the Inter-departmental Committee on Social Insurance and Allied Services appointed in June 1941 by the Minister without port-folio, then responsible for the consideration of reconstruction problems. Sir William Beveridge acted as Chairman of this committee. The report is voluminous. It would take hours to go over it in detail. What it is in substance can be expressed in these few words, viz:— "It is first and foremost, a plan of insurance—of giving in return for contributions, benefits up to subsistence level, as of right and without means test, so that individuals may build freely upon it." It plans to unify all now existing insurance schemes under one Government bureau, so that health insurance, cash sickness, benefit, unemployment benefit and the many others will be paid for by one weekly contribution. The plan literally covers all citizens from the cradle to the grave. A comprehensive health service is to be organized to give domiciliary and hospital treatment free and which is to carry on through re-habilitation until the individual is fitted to resume his or her occupation. Alas Sir William in his report fails to tell just what part the medical man is to play in all this. Details are to be left to the Minister of Health.

One recommendation made will certainly have the approval of all medical men. Cash benefit and medical benefit are once and for all divorced. In other words the doctor who treats the sick person is not made to certify to the illness in order that he, the sick person, may obtain his cash benefit. The English Panel Doctors have fought for this divorce for years.

One more item in the Report is of special interest. Private practice particularly in the specialties will go on if the Plan is accepted, but the field will become so narrowed that there will be less and less inducement to enter it. This implies without definitely stating it as a fact that practically the whole medical profession in England will become servants of the State.

With all these vast plans for social betterment springing up around us, can we possibly resist the contagion and be content with the many substitutes that are being tried on a small scale in various parts of our country? I say "we" in a large sense, for I do not believe that "we" in the restricted sense of the Medical Profession will have much to say about it. If enough of our individual States were sufficiently State-minded to introduce really radical social legislation of their own it might be possible to keep such legislation where it belongs, in the hands of the individual States. Such a thing does not seem possible. Here in Rhode Island we have made a start. Our new Cash Sickness Compensation Act is an opening wedge.

The Act was passed by the 1942 General Assembly and became effective May 10, 1942 although benefits will not begin until April 1, 1943. Rhode Island has the distinction of being the first State in the Union to embark on such an experiment and we may be sure that other States and the powers in Washington are watching the success or failure of our experiment with the greatest interest.

The object of the Act is to supply financial aid to workers whose earnings are lost through sickness. The influence of Labor is clearly shown in the inception of the Act. The State Unemployment Compensation Fund had grown to such size that Labor began agitating either for a lowering of contribution by employees or some sort of increased benefit. This agitation was fully justified. Because in the five States requiring employee contributions to the Unemployment Compensation Fund, Rhode Island workers pay a higher percentage than those in other States. And so to provide moneys for sickness compensation each employee shall contribute to the Rhode Island Cash Sickness Compensation Fund with respect to employment after June 1st, 1942 an amount equal to 1 per centum of his wages paid by his employer up to three thousand dollars in any calendar year. Each employer shall be responsible for withholding such contributions from the wages of employees at the time such wages are earned or paid. This one per cent is diverted from the 1½% that has heretofore gone to the Unemployment

Compensation Fund. The Act is administered by the present Unemployment Compensation Committee.

One per cent of funds collected are set aside for administrative purposes by law. This low cost would not be possible if the offices and administrative officers of the Unemployment Compensation Fund were not available for use in administering Sickness Compensation. Since all of these expenses are met by our Federal Government through funds provided by the Social Security Act it is evident that Sickness Compensation is not exclusively of Rhode Island, being suckled as well by a maternal Government.

Your Committee on Public Health meeting with the Committee to study the Rhode Island Cash Sickness Compensation Act of the Providence Medical Association in consultation with the Unemployment Compensation Commission pointed out to the Commission that in case the Federal Government withdrew its support, the 1% now alloted by law for administration would be totally insufficient to meet the cost, and suggested that an amendment be put through the Legislature allowing at least 4% of moneys collected to be used for administration.

The details of the administration of the Act are left entirely to the Unemployment Compensation Commission. There are two paragraphs in the Act that give them suggestions as to how to proceed. In sub-section (13) of Section 2, "an individual shall be deemed to be sick in any week in which, because of his physical or mental condition, he is unable to perform any services for wages." And again under Section 16, "This Act shall be construed liberally in aid of its declared purpose, which declared purpose is to lighten the burden which now falls on the unemployed worker and his family." There are other sections of course, in the act that are guides to the amount and duration of cash payments. The total amount of benefit to which a worker is eligible is determined by the total wage during a "base period" and this base period is defined as the calendar year immediately preceding the benefit year. That is, if an individual has earned only 100 dollars in the base period, cash compensation credits total only 34 dollars and this is paid out at the rate of $6.75 weekly until exhausted. If on the other hand the worker has earned 1800 or more dollars during the base period, the benefit credit is 364 dollars and 50 cents and this is paid out at the rate of 18 dollars weekly until exhausted and represents the highest weekly benefit under the Act. Intermediate amounts earned naturally entitle the worker to commensurate benefits. All this is clearly defined and easily followed.

How sickness is to be reported and by whom it is to be certified really constitute the difficult details that have been worked out by the Commission. Cards have been prepared with space for claimant's statement above and the attending physician's statement below. One of these cards properly filled out and signed must be sent in each week during which compensation is claimed. Right here we run into difficulties. How is "attending physician" to be interpreted? It necessarily must include osteopaths and chiropractors since they treat a very sizeable portion of our population and legally have nearly equal rights with men possessing an M.D. degree and again if the Act is to be interpreted liberally, it should include naturpaths, Christian Scientists and practitioners of other cults since members of their cults through error have periods of sickness just as the rest of us do. If this veritable hodge-podge of dealers in human illness are to have the right to certify sickness, what about reasonably scientific diagnosis? The data accumulated by the Commission concerning types of illness and seasonal illness will make very valuable statistics if properly handled, but will be of no earthly value unless diagnoses can be checked by some competent medical authority. With this in mind the Committees of the Rhode Island Medical Society and the Providence Medical Association meeting with the Unemployment Compensation Commission recommended that a full time Medical Director be secured to administer the sickness phase of the Act.

As I have said before, in the Beveridge Plan the attending doctor is not required to sign certificates for cash benefit. It is regrettable that some scheme for divorcing the two cannot be found for our Rhode Island Act.

As I look into the future, however, I must confess to a feeling that all these plans being put forward are merely temporary; that they are sure to be swept aside by something larger and more all-embracing. Refer back to the Bill introduced by Senator Green and remember what he says in justi-

fication of it, that by a slight increase of contribution to Social Security our workers will gain freedom from fear and freedom from want. The benefits given by Senator Green's Bill do not of course duplicate those given under the Rhode Island Sickness Compensation Act. Very soon, however, another Senator equally zealous to benefit his fellow men, will be asking for more amendments to the Social Security Act, calling for larger contributions to pay for the same benefits our workers are to receive under Sickness Compensation, and then alas the very laudable effort Rhode Island has made to maintain her independence in purely State affairs will be overshadowed by the greater power of the Federal Government.

The fate of all the other experiments being tried, such as the Blue Cross, the Blue Shield, the Michigan Medical Plan, the California Plan and a host of others will be the same. Their intent is most excellent, but their extent is insufficient to satisfy the wide enthusiasms of our experts in Social Security. No voluntary plan will satisfy their enthusiasms.

As a matter of fact voluntary insurance has never been successful wherever tried. The very ones the insurance is aimed to benefit do not join in any great number because the working man will not as a rule part with the least bit of his hard earned money to save himself from something that may never happen. Then too, voluntary insurance is one-sided in that the insurer pays all of the cost. If the insurer knows that capital and Government are sharing the costs with him, he *is* content to feel he is getting something for nothing. Something that he can demand and get and since he can demand it and get it, surely it is his by right. We hear the phrase "Wave of the Future." Someone has said that the wave of the future is the rising tide of labor, and that rising tide of labor will certainly be behind whatever in its opinion will bring the security it longs for.

The Medical Profession never has been and never can be an "organization in restraint of trade," in spite of the Court's ruling to the contrary. The best we can do, is to use our united influence in shaping future legislation so that some measure of the fine flavor of medical tradition will be left in the land.

68 Brown Street

THE TREATMENT OF PNEUMONIA WITH LARGE IMMEDIATE DOSES OF SULFONAMIDE WITHOUT COMPLICATIONS

JOHN F. KENNEY, M.D., F.A.C.P.

Read at November Meeting of Pawtucket Medical Association.

Since the publication of Evans and Gaisford of London and Long of Baltimore in 1938 and 1939, much has been written about the clinical properties and clinical results in the use of Sulfonamides together with the toxic dangers. Lately, articles are appearing advocating the use of large or small doses and particularly concerning the serious complications such as anuria resulting from the use of these drugs.

These same reports are put in such a way that they may do harm to the average practitioner without hospital associations, making him somewhat timid about using the drug or if he uses it, he has not the courage to carry out efficient treatment as the cases I have to report will show. Not that the dangers of these valuable drugs should not be brought to his attention; but considering the wonderful effects in pneumonia and how relatively infrequent these dangers are in comparison with the drugs used for other conditions, their use is indicated. It is with this thought in mind that I wish to report our experience at The Memorial Hospital, Pawtucket, R. I. Since 1939, we have treated over 350 pneumonias on all hospital services including private patients. On going over the records, I find, excluding nausea and vomiting which occur infrequently now with sulfadiazine, an occasional reporting of a rash or of *sulphur crystals* in urine, the only serious complication is one case of anuria; and this was not in a case of pneumonia and it is to be noted this blocking occurred with only a small dose of the drug.

During 1940, every case on medical service where practicable was given intravenous sodium sulfapyridine with no complication.

I wish to call attention also to a report of Rosenthal, MacColl and Joseph Pratt in the N. E. Journal of Medicine of May, 1942, of 130 cases treated at home without complications. Helwig and Reed of Kansas, J.A.M.A., June 13, 1942, report a fatal case of anuria following sulphadiazine therapy,

pointing out in this case that it was not a mechanical blocking of the tubules but that it is a tubular poison causing a degeneration of the tubular epithelium, and thus mere drainage will not relieve this condition. Lehr, they point out, carried out experiments on albino rats and found that sulfadiazine may produce an acute precipitate of free drug in the renal tubules and because of the poor solubility of the drug cause a severe degeneration of the tubules.

Case No. 1:—Mrs. E. K.—American—Married—Occupation: Mill Inspector—Age: 28—(Case seen in consultation by me seven days after admission.)

Admission Diagnosis: Pneumonia. *Admission Date:* June 1, 1942.

Chief Complaint: Cough and fever.

Past history and family history: Irrelevant.

Present Illness: Patient complained of a sore throat one week ago with a cough of two days. Later she had a chill and fever with pain in the left chest and moderate amount of dyspnea. Stayed in bed at home for 2 days and hospitalized.

Physical examination: Negative except for chest. Dullness over left chest posteriorly from scapula down with slight increase in voice sounds. Moist rales heard in both lungs but especially the left lung in the upper lobe. W.B.C. on admission 19,500. 79% polynuclears. *Sputum:* Few organisms resembling pneumococci, type not determined. All other laboratory procedures were negative. *X-ray Report:* June 2, 1942—Scattered infiltration throughout the lower two-thirds of left chest and to a slight extent in the right lung. The x-ray interpretation noted that while the changes may have been due to a disseminated pneumonia, nevertheless, the infiltrations especially on the left side were somewhat suggestive of a pulmonary, military type, of tuberculosis.

Continued sputum examinations were negative for tuberculosis. Sulphadiazine was instituted on admission, 7.7 grs. every 3 hours, by attending physician but temperature continued to 101 degrees and 103. I was asked to see the case and on physical examination did not feel that it was tuberculosis. Signs, symptoms and history pointed to pneumonia and an insufficient amount of sulphanomid drug. On June 7, 250 grs. were given in the first 24 hours followed by 100 grs. in the next 24 hours. Level rose from 2.1 on June 7 to 17 mgms. on June 8, and remained above 8 until June 11th. The temperature became normal on June 11 and the patient's condition markedly improved. She was discharged on June 18th. X-ray report on June 16 now showed complete resolution of the disseminated process in both lungs with a very slight residue in the left base. Final x-ray diagnosis was a pneumonic process and not a tuberculous.

Case No. 2:—Miss N. J.—Age 25—Stenographer. Admitted: 2/28/42. Sent to private service of Dr. J. F. K. with diagnosis of cardiac condition, and pneumonia.

Admission Diagnosis: Lobar Pneumonia.

Chief complaint: Cold, 5 days.

Past history and family history—irrelevant.

Present illness: 5 days before entry, patient developed a cough and mucus but no sputum since the first day. Chilly sensations and marked shortness of breath. Headaches and constipated.

Physical examination: Negative except for chest. Chest: Movements equal but labored. Question of slight dullness over scapular region in right. Breath sounds not decreased. Occasional wheeze. Fremitus normal.

X-ray on admission showed right upper lobe pneumonia. Temperature on admission was over 105. Patient had been given small doses of sulfathiazole by an attending doctor on the outside. Sulfadiazine 421 grams given in 30 hours. Sulfadiazine level of 11.6 mgms. obtained in 24 hours and a level about 8 maintained from 2/28/42 to 3/5/42 when temperature reached normal. Urine showed sulfa crystals on 3/6/42. X-ray report on 3/9/42: Re-examination of the chest, compared with the previous examination made 2/24/42 now shows almost complete resolution of the pneumonic process in the right upper lobe with only a slight residual infiltration. Patient discharged as recovered on 3/12/42.

Case No. 3:—S. M.—Widower—Retired—Age 59—*Admission Diagnosis:* Diabetes. Lobar Pneumonia. Case seen in consultation by Dr. J. F. K. on April 16, 1942.

Chief complaint: Difficulty in breathing. Diabetes.

Past History: Diabetes for years. *Family history:* Irrelevant.

Present illness: Patient states that he has had diabetes for years and taking protamine insuline. He has been nervously and emotionally upset recently and started to cough up phlegm and run a temperature.

Physical examination: Well developed and nourished white male, lying in bed, slightly dyspneic. Remainder of physical examination negative except for chest. Respiratory movements are free and equal. Question of dullness over left upper chest posteriorly. Exaggerated breath sounds over left upper chest anteriorly and posteriorly. Diminished resonance over the same area. Diagnosis: Left Lobar Pneumonia.

W. B. C. 9,650; 81% polys. Urine sugar and acetone. Sputum: large number of pneumococci but type not determined. (He had been given small doses of sulfathiazole before admission.) Blood sugar 119. X-ray report: Examination shows considerable haziness of left chest with slight elevation of diaphragm and apparently some displacement of mediastinum. Question of some degree of atelectasis of left lung principally of left upper lobe. Temperature on admission 100 degrees and it dropped to normal the next day, remaining around 99 and on the 5th day went to 100. On the 7th and 8th days, 375 grs. of sulfadiazine given. Temperature went to 103 and then down to normal and remained so until patient was discharged. A level of sulpha at about 14 mgms. was maintained for several days. Urine on discharge: Negative albumin. Sugar, Acetone 0. Blood sugar 125 mgms. on 30 units of protamine insuline.

Case No. 4:—Mr. L. W. P.—Married—Age 31—Machinist—Sent to the private service of Dr. J. F. K. on May 11, 1942. *Admission Diagnosis:* Lobar Pneumonia.

Chief complaint: Pain in the right chest. Fever of 10 days' duration.

Family history: Irrelevant. *Past history:* Pneumonia 10 years ago.

Present illness: Patient states that he was perfectly well until 10 days ago when he began to feel weak and tired. The following day he went to work but had to come home. He began to have pain in his right side and was feverish. He called his own doctor who gave him pills. Two days later, he called in another doctor who treated him for a week and then called in the present attending physician as a consultant. It was agreed that the patient should be hospitalized.

Physical examination: Well developed and nourished male in bed, with some discomfort. Remainder of physical examination negative except for chest. Symmetrical. Slight limitation of motion at right base. Dullness over the right base on percussion. Bronchial breathing over the same area with fine crepitant rales. *Diagnosis:* Right Lobar Pneumonia.

W. B. C. 16,550. 91% polys. Sputum: Few pneumococci. Streptococci predominated. X-ray report on admission: Shows haziness of base where diaphragm is partially obscured. The findings suggest pleurisy at left base possibly associated with a very small amount of fluid but no evidence of consolidation. Re-examination by x-ray, 8 days later, compared with the previous examination made 5/11/42 now shows complete absorption of haziness and suspected infiltration at right base. Patient's temperature on admission was 103.5 and as far as could be determined he had received about 200 grs. of sulfathiazole over a period of 10 days on the outside. We started him on sulfadiazine and he received 475 grs. over 48 hours to maintain a level of 11.2 mgms. for several days. The patient's temperature became normal in 48 hours and remained normal until discharge.

Case No. 5:—H. M.—Age 15—Student. Admitted 5/5/42. Discharged 5/16/42.

Admission Diagnosis: Medical Observation. (Patient seen in consultation.)

Chief complaint: Headache. Backache and fever for the past 4 days. Inability to urinate for two days.

Past history and family history: Irrelevant.

Present illness: Patient states that he was well until 4 days ago when he developed a severe headache (over entire head) and a backache in lumbar region. He became feverish and his L. M. D. was called who after an examination gave him pills without result. Patient became worse and his own doctor took him into hospital as his private patient.

Physical examination: Negative except for chest and abdomen. Expansion is slightly limited in right base. Dullness and diminished breath sounds over right lower chest with fine crepitant rales. Left lung clear. Abdomen: Rounded mass, dull to percussion, extending 3 inches above pubes, appears to be a distended bladder. Diagnosis: Right lower lobe pneumonia. Urinary Retention.

X-ray of chest shows a number of infiltrations in right lower lung extending downwards and upwards from the right hilus, consistent with presence of a pneumonic process at right lower lobe. W. B. C. 11,000; 88% polys. Urine: Specific gravity 1.010; very slightest possible trace of albumin; leucocytes. Patient was started by attending physician on sulfathiazole grs. XV every 4 hours for 3 days and a level of 2.8 mgms. obtained on 5/8/42. Case seen in consultation on 5/8/42. 390 grains of sulfadiazine given in the following 36 hours, bringing up the level first to 8, then to 17.6 and maintained for 48 hours at 14 mgms. Temperature dropped from 102 which had been maintained for first 5 days after admission to normal on 5/10/42 and remained normal until discharge. No pneumococci found in sputum after admission to hospital. Urine and blood normal on discharge 5/16/42.

Case No. 6:—J. D.—Age: 19—Occupation: Back Tender. Admitted March 11, 1942. *Diagnosis:* Infection of skin and underlying tissue of right hand. Case seen in consultation with attending surgeon.

Chief complaint: Injury to the right hand. This was following an accidental crushing of the hand in a press, causing a compound fracture with a deformity of the proximal phalanx of the ring finger. Patient was discharged on April 6, 1942. Re-admitted on April 12, 1942 for repair work of the finger. Re-admitted on May 4th with the area on the finger draining pus, swollen and painful. On 5/8/42, the attending surgeon started sulfathiazole treatment, grs. XV every 4 hours. Condition became very poor. A level of only 2.8 was obtained. On 5/10/42, there was a complete suppression of urine. Blood chemistry showed a creatinine of 4.6, whereas, a previous blood chemistry done on 5/5/42 was normal. The usual treatment, packs, clyses, blood transfusion, together with catheterization of both ureters, was carried out. The temperature was normal from the 15th and the patient was discharged on 5/27/42 with a normal blood count and normal blood chemistry. Discharged improved.

COMMENT: A large number of cases of pneumonia have been treated by a number of physicians without any serious complication. Blood level is no criterion as to complications such as anuria, and blood level determinations should be encouraged, more to be sure that enough drug is being given rather than for a check on any toxicity. This is shown by low levels for first few days in the above reported cases, and the small doses and low level in the one case of complications reported. I feel that large amount of fluids should be given continually. The findings of crystals in urine should not be an indication to discontinue the drug.

The six cases reported were taken from my private service. There are many others from ward service. These were selected as cases which I personally followed.

Complications occur with small doses of the drug as well as with large doses but as stated previously, we have not had these occur with large doses. Cases, however, have been reported with larger doses. The giving of such large doses in a short time and the immediate discontinuance of the drug, instead of somewhat smaller doses with a gradual decrease may be open to debate. In favor of the former is our giving the drug (sodium sulphapyridine) intravenously during 1940 without complications.

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The late Dr. James W. Leech did many tonsillectomies in his day. When he was somewhere around fifty years of age he had to have his own tonsils removed. While convalescing in the hospital he asked to have the head operating nurse sent to his room. He said to her, "Miss Potter, I wish hereafter to make a change in my operating technique." "Yes, Dr. Leech." "From now on when you set out my instruments please see that there is a large sterile handkerchief on the table. For when it comes over me how that poor patient's throat is going to feel in a few days I am going to burst into tears."

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MEDICAL MEETINGS FOR 1943

The annual meetings of most of the national medical organizations have been canceled for 1943. This step has apparently been taken in most cases to ease the difficult transportation problems which our country is facing. In many instances the number of medical men in military service who will be unable to attend meetings is another reason for not planning such gatherings this year.

All of us who have been accustomed to the periodic stimulation and inspiration of gathering with our colleagues will feel the lack of these meetings this year. In spite of increased work for everyone and with diminishing opportunities for rest and relaxation, medical men can hardly afford to forego all professional meetings. This situation should make our local meetings for 1943 of increased significance to us, and the meetings of the district societies and the State Medical Society should enjoy a proportionately large attendance from members who are not away in military service.

The time and effort which go into the planning of any medical meeting impose a significant burden on the officers of all medical societies. The officers of our district and state societies are in most instances by virtue of their prominence in the profession already carrying more than their share of the medical work in our various communities. If they can devote the time and energy required in planning medical meetings, the rest of us can certainly give them our enthusiastic support by attending the gatherings and taking an active part in the programs and in the discussions.

The Rhode Island Medical Society will hold an annual meeting at the usual time this year. Presumably the program and other arrangements will be somewhat contracted for reasons that need no explanation. All members who are in better than tolerable physical health and who are not actually away on war missions should not fail to attend. The program will be worth your while, and your attendance will counteract any discouragement that may accompany organized medical activities in these troublous times.

RHODE ISLAND HOSPITAL UNIT IN INDIA

Not long ago we learned that the Unit was on the Pacific coast. Now news has been received of them in India. By what devious routes they travelled has not been disclosed. Presumably in the days before the world went haywire a group of Providence people desiring to see the land of tigers, elephants and the Taj Mahal would have ferried over to England, there taken the P. & O. steamer, stopping at Gibraltar and pleasant Mediterranean ports, then through Suez and the Red Sea. It would have been a few weeks trip marked principally by three square meals daily with tiffin, tea and numerous high balls;—pleasure associated with ennui.

But we have reason to believe this strikingly different. Where they disappeared to after sailing out into the Pacific it seems useless to conjecture. But we know that wherever they went they were in danger. The mere fact that they were doctors

and nurses whose sole duty was to help sick or wounded humans gave them no immunity whatsoever. This is a terribly logical war. The Japs and Germans are out to destroy all their enemies possible. Anyone working to save any of these enemies is hindering their purpose. So medical units on errands of mercy are as fair game as fighting forces.

But the families and friends of these officers and nurses are justified in heaving sighs of relief. To be off the seas and on the solid earth of India is to have one of their gravest perils disposed of.

As to where they go from there;—one guess is as good as another. Not being a radio commentator we can speak with no semblance of authority.

Let us trust they follow advancing troops steadily towards Tokyo.

CLINICAL PATHOLOGICAL CONFERENCE

at Meeting of

PROVIDENCE MEDICAL ASSOCIATION

March 1, 1943

Case presented by

ANTHONY V. MIGLIACCIO, M.D.

Patient: Age: 78. Admitted: January 18, 1943. Discharged: February 2, 1943.

Chief Complaint: Epigastric pain and vomiting for five days' duration.

Present Illness: Suddenly five days ago, patient began to have severe epigastric colicky pain, which was also felt at a point three inches below the scapula on the right. Vomiting has been a constant feature and changed from a greenish color and bitter, to a dark-brown fecal-smelling material. The pain does not radiate and is attended with much gas. Change in body position does not help the symptoms. L. M. D. has had to give her six morphine injections during the past five days.

Past History: Thirty-five years ago had her ovaries, uterus and appendix removed. Remained well until two years ago when she had a spell of vomiting due to a gall stone, which was dissolved by L. M. D. She was admitted to the hospital and went home in one day at that time.

Following this episode the patient had to watch her diet. She avoided red meat, eggs, milk, butter, fried foods, pork and sweets. Cereals, vegetables and fruit were well tolerated.

Beginning one year ago she began to have epigastric pain but this was different from the pain experienced two years previously in that the pain and vomiting were more severe and more persistent. These attacks have recurred several times since. Has never noted the color of bowel movements.

Systematic Review: Negative.

Family History: Mother and father died of tuberculosis.

Physical Examination: An elderly widow who looks her stated age, having paroxysm of acute epigastric distress with vomiting. *Heart:* Normal sinus rhythm. Heart sounds difficult to hear but apparently no murmurs. *Blood Pressure:* 95.75. *Abdomen:* Large obese abdomen which is very soft—no spasm present. Tenderness present in the right costovertebral angle and in the epigastric area. There is some tenderness in both upper quadrants on deep palpation. Liver, spleen and kidneys not palpable. No hernia present. The patient was moderately tender to deep palpation at the tip of the xyphoid process. She states—she feels a fullness in her midepigastrium as if something were stuck there in her throat, with the material moving up and down.

Auscultation of Abdomen: Peristalsis moderately active. *Percussion of Abdomen:* Slightly tympanitic. No fluid wave or shifting dullness. There was no jaundice. Otherwise the examination was negative.

Laboratory Work:

Hinton: Negative

Hgb. 15.3 gms

W. B. C.

1-19-43 9,000

1-28-43 14,500

	1-19-43	1-26-43	1-30-43
Urea Nitrogen	69	29	43
Creatinine	4.3	3.0	3.1
Glucose	99	92	
Phosphatase Acid	2.7 K. A units per 100 cc		
Alkaline	6.7 K. A units per 100 cc		

3 urine exams not remarkable. Specific gravity 1015, 1015, 1016.

X-ray January 18, 1943: The chest shows no active pathology in the lungs. The diaphragm shadows are of normal outline and there is no fluid in the pleural cavity. Heart and vessels are not enlarged but there is slight flattening of the heart due to elevation of the left diaphragm. Upright film of the abdomen is unsatisfactory due to the patient's condition. There is a large sharply delineated, dense shadow, just above the crux of the diaphragm. There is a fluid level within this shadow which is consistent with diaphragmatic hernia.

X-ray January 28, 1943: Beside examination of the abdomen shows the Miller Abbott tube well beyond the stomach, and the distal end of the tube is in the jejunum.

Progress: The patient was admitted on the Medical Service on January 18, 1943. A Miller Abbott tube was inserted. Intravenous fluid was given, and a generally supportive regime was instituted.

The following day January 19th the patient was transferred to the II Surgical Service for a possible small bowel obstruction.

Surgical Note: January 23, 1943: Patient has stopped vomiting. Fecal character of vomitus would lead one to suspect intestinal obstruction. On examination, however, abdomen is soft and not tender, there is no hyperperistalsis. Has had poor results from enemas. X-ray shows a diaphragmatic hernia. Blood chemistry shows evidence of uremia. Vomiting could be due to both the uremia and the hernia but one would not suspect fecal vomiting in either. However patient is in no condition for surgery. Suggest medical treatment temporarily. Patient transferred to Medical Service. She pulled out the Miller Abbott tube. The blood chemistry showed improvement. Vomiting started again, and on January 27th was fecal in character again. The Miller Abbott tube was reinserted and fecal vomiting stopped.

Surgical Consultation: January 28, 1943: We feel that the vomiting is from a surgical mechanical condition. It may come from the diaphragmatic hernia but this is improbable. It may come from adhesions from previous operation. Do not believe that this patient will stand surgery at this time. Blood chemistry has improved slightly. Continue with Miller Abbott tube, fluids, etc. at this time. If condition changes for the better will consider operation later.

Medical Note: February 1, 1943: This patient is not improving. She is still having fecal vomiting. Her kidneys may show some failure but there is no albuminuria, and specific gravity of 1.016 is noted. I think that this is a surgical problem and that if her vascular collapse can be overcome, she should be operated. Today her blood pressure is 96/82 right and 80/72 left, as far as can be determined. She is duller and weaker this morning.

February 2, 1943: Blood transfusion was to be given. As the interne was about to do a venesection the patient took a few gasps and expired.

Discharge Diagnosis: (1) Intestinal obstruction due to undetermined cause. (2) Hiatus hernia.

This case presents many interesting angles. First, one wonders why the patient was not admitted to the hospital earlier. Persistent vomiting and pain which required morphia hypodermically, so frequently, surely are definite indications for hospitalization. It may be that the patient refused.

On admission, the diagnosis of intestinal obstruction is quite obvious. The cause of the obstruction, however, is the mystery. The x-rays are portable plates and, because of the patient's obesity, are poor. One can't tell whether there is small bowel distension or not. Neither can one see gas in the large bowel. Either one of these findings would help in localizing the lesion. If one was certain that there was gas in the colon, then it would be natural to suspect a malignancy of the large bowel. Without any gas in the large bowel, plus distended small bowel, then suspicion would be centered on the small bowel.

Because of the absence of fever, localized tenderness and because of the low white blood count, an acute inflammatory process seems unlikely, although in the aged this is not always so.

The x-ray findings of a diaphragmatic hernia does not make the problem any easier. Apparently the stomach is the only organ involved in the hernia. Could it be possible that there is a kinking or twisting of the transverse colon, as it is dragged up by the stomach? The diaphragmatic hernia undoubtedly has been present for years, as there is no history of accident, which could have caused this recently.

If this assumption is correct, then it is only natural to assume that the hernia should have caused more trouble in the past, than it has, and that decompression of the stomach should have relieved the obstruction. Because of these factors, I feel that the hernia is only an incidental finding and has no bearing on this case.

The high urea nitrogen and creatinine, in an old woman, show that there is some kidney damage. The medical note seems to indicate otherwise, but the fixation of the specific gravity of three urines (1.015, 1.015 and 1.016) make me wonder. With uremia, vomiting is common but fecal vomiting is rare. The blood findings are probably partly due to the electrolyte and water loss associated with the vomiting. The improvement from 69 mgm. to 29 mgm. of urea nitrogen, noted with the institution of corrective measures, bears this point out. Even though the same measures were continued, the urea nitrogen rose from 29 to 43 mgm. The creatinine was constantly elevated. These factors undoubtedly are indicative of underlying renal pathology. The absence of hyperperistalsis usually found in intestinal obstruction, makes it probable that there is at least an underlying paralytic ileus. This is found in uremia, but it is also encountered in mechanical obstruction, which has existed for some time, where the bowel finally tires out. The latter seems to be the more reasonable of the two, in this case.

Because of the patient's age (78) and the persistent low blood pressure, some cardiac damage is to be expected.

The absence of: 1. anemia; 2. history of diarrhea; 3. loss of weight, plus sudden onset of the present illness, rules out a lesion in the right colon. With lesions of the left colon, vomiting is a late manifestation, and severe pain is unusual, except in a ruptured diverticulitis, which has already been ruled out.

Retroperitoneal lesions such as sarcoma, which creeps in between the peritoneal layers of the mesentery, and then encroaches on the bowel lumen, must be thought of but are quite rare.

This leaves us only with the small bowel. The lesion must be in the ileum or otherwise the vomitus would not be fecal in character. Meckel's diverticulum, polyp, or carcinoma, would be more apt to give, at the start, an incomplete or intermittent obstruction. Intussusception of nineteen days' duration, without more signs of an acute abdomen, seems improbable. The same can be said of volvulus or mesenteric thrombosis. I have never seen a so-called internal hernia. A Richter's hernia would have cause more localizing signs. The old history of gall bladder disease, the pain at onset, which was localized to scapula, as well as in the epigastrium, plus the suggestion of tenderness in the upper abdomen, make one ponder over the possibility of an obstruction due to a gall stone; but here again one is overcome by its rarity. This thought reminds me of a case which the late Dr. Henry Hoye had in 1929, of intestinal obstruction in a patient like the present one, who was in very poor physical condition. After five or six days of prayer and enemas, the nurses and the doctor were rewarded with three beautifully facetted stones. These stones were proudly displayed in the Staff Room at the R. I. Hospital. To clinch the diagnosis, Dr. Hoye was prevailed upon to have the stones examined. Dr. Clarke found that they were fecaliths and not gall stones. This too, seems improbable.

Now, remembering that a "thing is most apt to be what it is most apt to be" we come to the most probable diagnosis, and that is obstruction of the terminal ileum due to adhesions from the old pelvic operation. This diagnosis is arrived at by exclusion and like most diagnoses so made, is probably wrong. Remember that the patient also has: 1. Chronic myocarditis; 2. Chronic nephritis; 3. Diaphragmatic hernia.

Discussion

Dr. Burgess: I don't think the patient had nephritis. All the findings pointing to that could be due to intestinal obstruction and vomiting. There were not enough urine exams to be of value but I think uremia can be ruled out. The patient apparently was in continuous shock and not in shape for surgery.

Dr. Jesse Eddy: There were no biliary tests done and I think they should have had some. The fact that the patient lived for sixteen days while vomiting showed she was strong. She lost large amounts of electrolytes and fluids. I think she should have had more x-ray studies. She evidently had intestinal obstruction.

Dr. Benjamin: The prevalence of gall stone ileus should not be ignored. We had three proven cases at the Memorial Hospital in nineteen months. The diagnosis should be made by x-ray.

Dr. Martineau: The x-rays in this case had to be bedside exams. She was markedly obese with a big apron of fat which obliterated the findings.

Dr. Harrington: This patient could have had a thrombosis of the mesenteric artery as the low blood pressure would predispose to this.

Dr. Butler: A barium examination would have cleared up the problem of the contents of the diaphragmatic hernia and told whether the colon was included. Gall stone ileus is not uncommon.

Dr. Migliaccio: There is a good article on gall stone ileus in a recent number of the American Journal of Surgery. These are rarely visualized in the small intestine. There is a big mortality associated with it. You must understand that this patient came in practically moribund and pulled out the Miller Abbott tube which we had inserted interferring thus with our treatment and plan of investigation. I feel that biliary tests are now generally considered of little value. They might as well be thrown out the window.

Dr. Batchelder: Only three percent of gall stones are calcified. Therefore they are rarely visualized in the small intestine.

Dr. Clarke: What do you consider the cause of the dramatic terminal episode?

Dr. Migliaccio: I can't explain this. She was very sick and anything might have happened.

Dr. Clarke's Discussion: The terminal event proved to be a pulmonary embolus. There was a thrombus riding the bifurcation of the pulmonary artery. It was about six inches long and its calibre indicated that it probably came from a femoral vein.

There was no evidence of chronic nephritis. The changes in blood chemistry can be best explained on the basis of high intestinal obstruction with vomiting.

Neither was there any important heart lesion. There was much fat in the epicardium and some fatty infiltration of the myo cardium. There was a mural thrombus on the lining of the right ventricle. Her condition of dehydration probably predisposed to thrombus formation since under such conditions the specific gravity of the blood is raised, it becomes viscid and the rate of circulation is markedly slowed.

The upper eight feet of the jejunum was distended and its wall congested and edematous. Below this it was collapsed and empty. At this point of obstruction the lumen was occupied by an egg shaped gall stone 3.5 cm. in diameter. There were many old fibrous adhesions between the gall bladder and the duodenum. When the gall bladder was opened there was found to be a large communication between it and the lumen of the duodenum.

Diagnosis:

1) Chronic cholecystitis.
2) Cholelithiasis.
3) Cholecysto-duodenal fistula.
4) Intestinal obstruction (gall stone).
5) Pulmonary embolism (terminal).

NEWPORT COUNTY MEDICAL SOCIETY

The regular meeting of the Newport County Medical Society was held on Tuesday night, February 23rd, at 8:30 at the Newport Hospital Auditorium. Dr. Louis E. Burns, president, presided.

Dr. William P. Buffum of the Rhode Island State Society was presented, and gave a short talk on the new set-up of the Rhode Island Medical Society. He mentioned that new by-laws had been adopted whereby members, becoming members of local Medical Societies would automatically be eligible for membership in the Rhode Island State Society upon payment of the usual State dues. It was also stated that members of the State Society beginning July 1943 would have a $15 war tax imposed yearly to make up the deficit in the treasury due to the remittance of dues of members serving in the Armed Forces. Dr. Buffum's statement seemed to meet with approval.

The speaker of the evening was then introduced as Captain George Eckert, M.C.U.S.N., Executive Officer of the Newport Naval Hospital. Dr. Eckert was on the hospital ship in Pearl Harbor during the infamous bombing of December 7, 1941.

The speaker said all types of war wounds were received on the hospital ship during the bombing itself, but that they were expeditely sorted under

these unusual circumstances. Shock seems to be the greatest cause of death in war wounds, particularly those occurring 8 to 12 hours immediately after. Three types of shock:

Primary, the first 8 to 12 hours, usually due to loss of plasma.

Secondary, anywhere up to 2 days, when hemoconcentration is present.

Third degree, which is not common, which is, nevertheless, the worst of all, and the hemoconcentration is more severe.

It was found important to give all patients morphine sulp. gr. ½, immediately, as this prevented psychic trauma to a great extent; this, of course, particularly during air raids, bombing, etc. All patients were given anywhere from 500 to 1000 c.c intravenous plasma, and this was repeated later if found necessary. Plasma very important in the burned cases. Blood transfusions were given for the usual secondary anemias. Most of the cases were sprayed with 10% tannic acid until a firm eschar was formed. Some were painted with a 2% silver nitrate solution after the first coat of tannic acid. Silver nitrate was used mostly on cases which were losing fluid rapidly.

Due to the unusual circumstances present, it was impossible to observe sterile technique or to follow through with laboratory work. But the results were good in spite of this. Also, debridement was not done for 3 - 4 days. Cradles were improvised from barrel staves, etc. until others could be brought to the ship. All parts of the body including faces and hands were treated in like manner with tannic acid spray, the eyes being protected.

The experience seems to show that early debridement seems unnecessary, and also helps to prevent further shock. Fuel oil in the burns and wounds was a great problem, and seemed to aggravate shock. And these patients, when the oil was removed with green soap and water, seemed to recover quicker from the shock condition. It seemed necessary to remove the oil from the wounds to facilitate a good eschar forming. Other forms of treatment called for forced fluids, and these were given by mouth every hour, as it was impossible to set up enough intravenous apparatus for so many patients.

Cortical extract was not used. Although the speaker did not favor tannic acid for all types of burns, it seemed to be excellent treatment for 1st and 2nd degree burns with which they had most to contend. The good results seem to be due to early treatment. Sulphanilamide gms. 4 was given internally to all patients where infection or toxemia seemed to be present.

After the eschar was formed on the burns no further treatment seemed to be needed for 3 - 4 days, when the coagulum was removed as easily and gently as possible. This was followed by vaseline guaze, under sterile precautions, followed later by wet saline dressings.

Foreign bodies such as pieces of shrapnel, were let alone for several days. The wounds were packed with sulpha. powder and most did well. Early operation on two cases for removal of shrapnel proved fatal, and the speaker believed that this was due to shock.

In cases treated in the Naval Hospital in Honolulu where variety of treatment was used, the mortality and morbidity was higher than in his (Dr. Eckert's) cases, justifying the conclusion that early and adequate shock treatment counts most regardless of the type of burn treatment. The old dictum of certain amount of body surface being burned indicating the result of the case, did not seem to hold.

Summary of treatment:

1. Protect burn area.
2. Combat shock.
3. Relieve pain.
4. Minimize fluid loss.
5. Protect against infection.
6. 4 gms. sulfadiazine or
7. sulfanilimide orally.
8. Morphine gr. ½ doses.
9. Open or closed treatment for burns, although at Pearl Harbor, only closed treatment was used.

Dr. Eckert's paper was heartily received and brought forth many comments of the excellent treatment rendered by the Naval Doctors in this unexpected emergency.

The meeting adjourned at 10:10 P.M. A collation followed.

ALFRED M. TARTAGLINO, M.D.
Secretary.

BEGINNINGS OF OCCUPATIONAL THERAPY AT RHODE ISLAND HOSPITAL

Miss Jessie Luther

Although the value of occupation in cases of mental disorders has been known and recorded from time to time during centuries, and has been applied as an organized form of treatment since 1904 at the Handcraft Shop (a small sanatorium) at Marblehead, Mass.; at Butler Hospital since 1906 and at about the same time at Bloomingdale Hospital, N. Y. and a few private sanatoria, all psychopathic institutions; such treatment had not been employed in other forms of disability until conditions among our overseas soldiers in the First World War gave impetus to the movement. We began to hear of restlessness and discouragement among convalescent patients in base hospitals behind the lines and the need of occupation to strengthen morale.

During the winter and early spring of 1918 tentative efforts were made to train classes in crafts with a view to possible overseas service, but these courses were too brief and inadequate to be very effective. Of more value were professional and amateur craftswomen, some of whom volunteered for service with the Red Cross and other units in France and did good work with, at first, little encouragement and less material help. At this time an effort was made at Washington, D. C. to establish an occupational therapy training school for craftswomen as volunteers for overseas service. Having been asked to assist in this school I waited until the plans, although definitely made, proved futile due to complications at Washington and then found a field for effort nearer home which proved to be Rhode Island Hospital.

Dr. John Peters, then superintendent, was in favor of occupational therapy but its application in general hospitals was, at that time unrecognized by many physicians who failed to appreciate its value in any but mental cases — and were sometimes skeptical in any case. One of the arguments against use of crafts as a treatment in any general hospital was a misconception of its purpose. The idea seemed to prevail that such training was intended to fit the patient for a new form of livelihood after his hospital discharge and the usually short period allowed for hospital residence would not allow time for adequate training and experience in a new type of work. The idea of the use of crafts or diversion as a mental and physical treatment aside from the economic or utilitarian aspect was not understood until later.

My work began in the spring of 1918 with two or three afternoon visits a week —, all I could spare from my regular duties as Occupational Therapy Director at Butler Hospital.

Owing to lack of hospital appropriations, materials were financed by the Social Service Department; I think as a special fund. Occupations consisted of simple crafts; basketry, (both reed and raffia); braiding rags for mats, knitting, and I think a little crochet. It was conducted mostly in Wards K and H.

The patients were men, women and boys, some in bed; some in chairs and several in small, self-propelled carts which they managed with remarkable dexterity. Men and boys made baskets and some braided mats, braiding was also done by some women. Knitting was done by women and one or two men had learned to knit scarves. The articles were helmets, sweaters, stockings and scarves for men overseas and sometimes there were gifts for friends or for personal use made from their own material by some of the women.

Accomplishment was limited owing to the patient's effort and ability as was to be expected, but everyone tried and I do not remember anyone who failed to show some intent and finally cooperation. I enjoyed my hours with them. For the most part the patients were short time cases— convalescents from different forms of disease, — post operative; accident cases, perhaps some cardiac, I do not now remember.

In August General Pershing visited the A.E.F. base hospitals in France; saw the 50% improved condition of wounded soldiers who were given occupation by the volunteer women and sent for 1000 trained aides. I enlisted for overseas Occupational Therapy Aide in Sepetmber and my work at Rhode Island Hospital came to an end.

Mrs. James W. Thornley, a craftswoman and associate of the Handicraft Club carried on the work with interest and efficiency until installation

of a definite Occupational Therapy Department with appropriate quarters and equipment made possible the fine development and effectiveness that we find at the hospital today. I am happy to have had a small part in preparing the way for this department and its development.

BOOK REVIEWS

AUTONOMIC REGULATIONS, THEIR SIGNIFICANCE FOR PHYSIOLOGY, PSYCHOLOGY AND NEUROPSYCHIATRY. By Ernst Gellhorn. Interscience Publishers, Inc. New York $5.50. December, 1942.

In this very readable book Dr. Gellhorn has undertaken to put together our knowledge of the function of the Autonomic Nervous System and the part that it plays in the activity of the organism as a whole.

Nearly a century and a half ago Bichat defined life as the sum of the forces that resist death. With the rise of general physiology, much of modern physiology has come to emphasize detailed investigations of the chemical and physical processes involved in cell function. But in recent years Cannon, in his books "Bodily Changes in Pain, Hunger, Fear and Rage" and "The Wisdom of the Body", has presented a modern view of the organism functioning as a whole, not unrelated to that of Bichat, which he has called *homeostasis* — the tendency of the organism to retain its original state, or to restore it when it is departed from.

It is from this point of view that Dr. Gellhorn's book is written. "The discovery of the principles by which the purposeful reaction of the organism is retained under stress and strain becomes the supreme task of an organismically oriented physiology, their application the problem of a scientifically oriented medicine and physiology."

The physician who has felt that the researches of modern physiology are only remotely connected with his problem of dealing with sick individuals will here find some of them oriented for his benefit. The more or less intangible characteristics of people, that serve as the basis of the "hunch" of the successful diagnostician, begin to have a scientific significance in this sort of physiology. Certainly here are clues to a scientific understanding of them.

The first two parts deal with the structure of the autonomic nervous system and the adjustment reactions in which the respiratory and circulatory systems are primarily involved. Part III deals with the integration of autonomic and endocrine activities, emphasizing their mutual interaction with a complete review of the pertinent literature. Similarly the mutual relation between the autonomic and somatic nervous systems is covered in Part IV. The discussion in Chapt. XIII of the carotid sinus reflexes admirably illustrates the organismic or integrative point of view. The suggestion, developed in Chapt. XVI, that the adjustment reactions which tend to restore the original conditions of the body are the result of an integration of autonomic and cerebrospinal processes is supported by an interesting and convincing selection of material. The last section deals with clinical results and applications, with a chapter on general and spinal anesthesia and one on the autonomic nervous system and neuropsychiatry in which there is a discussion of the mechanism of the action of agents used in the treatment of schiozophrenia.

Each chapter concludes with a concise summary of its significant high points, and there is an exhaustive bibliography of 1100 titles. It is to be hoped that the general reader, whose physiology courses may be many years behind him, will not be frightened off by the many graphs and kymograph records throughout the book. These naturally give to the reader who is habituated to their use, a vivid presentation of a great deal of detail that would be presented otherwise only with difficulty. They are necessary to give weight to the discussion particularly for those who might view it critically or sceptically. The general reader may well take their contents for granted and should find no difficulty in understanding the context they are supposed to support.

J. WALTER WILSON, Ph.D.

THE ANATOMY OF THE NERVOUS SYSTEM. By S. W. Ranson. Seventh Edition, revised. W. B. Saunders Company. 1943.

A new edition of this standard textbook of neurology hardly needs a review addressed to a profession which must be thoroughly familiar with

the previous editions. To anyone having a use for a knowledge of neurology it has for many years been indispensable. In each new edition Dr. Ranson has collected all the important new advances in this subject, and, with the reliable judgment of one of the most active investigators in his field, he has oriented them in the body of established knowledge. In this edition more physiology has been added and there has been an extensive revision of the sections on the cerebellum, thalamus, hypothalamus, cerebral cortex, and sympathetic nervous system. The superb book work characteristic of many of the Saunders texts, with the fine reproduction of the numerous figures, many of them in color, makes it a very attractive volume.

It is to be regretted that owing to his recent death this will be the last revision by Dr. Ranson. The publishers announce however that future revision will be in the hands of Dr. Sam L. Clark of Vanderbilt University School of Medicine, so that its successful continuance in the future seems assured.

J. Walter Wilson, Ph.D.

Doctors of the Mind by Marie Beynon Ray. Little, Brown & Co., Publishers.

This is a book written for the general reader and not particularly for the physician or the psychiatrist. The author, who is an experienced writer, has made an exhaustive study of the history of man's development, starting with "Degenerate Adam or Perfected Ape" and discussing the advances and progress in the study and treatment of diseases of the nerves, and then of mental diseases, up to occurrences within the past six months. It is carefully written and in interesting language. At times, as one would expect, the point of view is quite different from that of the man trained in medicine. Again the greater attention appears to be given to the more dramatic aspects of treatment, and some of the newer aspects of physical measures, such as shock therapy of various types, are more emphasized than various measures in what is strictly psychotherapy. The physician will find this work easy, interesting reading and, although written in popular language, it will bring him up to date on the latest advances in psychiatric treatment.

Niles Westcott

The Mask of Sanity by Hervey Cleckley, B.S., B.A. (Oxon.), M.D. Professor of Neuropsychiatry, University of Georgia School of Medicine, Augusta, Georgia. C. V. Mosby Co., Publishers.

There is a border line between the fields of the psychiatrist and the legal profession which may be said to be inhabited by those who are problems for both, sometimes called the "Constitutional Psychopath" or the "Psychopathic Personality" or the "Contstitutional Psychopathic Inferiority". In this book of about three hundred pages Dr. Cleckley makes a masterful attack on the presentation of the subject. He has had unusual preparation for a study of the subject. He is a teacher of medicine, has been connected with a large neuropsychiatric hospital, and has contact with more than his share of patients who have been under the care of various organizations such as those in charge of veterans of the former World War. This work gives an outline of the problem, stressing the prevalence of the disorders, the clinical picture presented, even when the patient is scientist, physician, or psychiatrist, and there is a careful distinction from other personality disorders; in other words, careful differential diagnosis. There are copious case histories, and finally an attempt is made to interpret the situation as to what is wrong, how such a change occurred, and finally "what can be done about it". While the questions are not fully answered, this is a splendid presentation of the subject and it should be stimulating to the psychiatrist and the man interested in legal medicine.

Niles Westcott

Mental Illness: A Guide for the Family by Edith M. Stern with collaboration of Samuel W. Hamilton, M.D. Commonwealth Fund, Publishers.

This is a carefully prepared manual for those who are in contact with mental illness through relatives or friends who have become hospital patients. It is written by one Edith M. Stern, who has had experience in the preparation of subjects for those who are outside the medical profession. Dr. Hamilton, who following a long hospital experience, has also been an officer of the National Mental Hygiene

Society, and is acting in an advisory capacity with the United States Public Health Service, has been able to advise and direct the material presented in this handbook. It is a masterpiece in its simplicity; —practical, understandable, and helpful. The writer touches on important legal points and many technical points which, if heeded, would make the hospitalization easier for everyone concerned. Dr. Hamilton stresses in his preface the need for a manual of this kind. For, no matter how carefully the admitting officer in a hospital may try to enlighten the relatives of the incoming patient, the actual time of admission is not the time to burden them with hospital rules and regulations. In a few words, this book, bridging the ground as it does between the patient in the hospital and the relatives on the outside, is a concise, well written, volume, fitted for a place, not only in the library of those who have relatives in the hospital, but also in the physician's office, as an aid to relatives of those who need to become in-patients.

NILES WESTCOTT

TEXTBOOK OF CLINICAL NEUROLOGY. By Israel S. Wechsler, M. D., W. B. Saunders Company.

For approximately fifteen years now and through the medium of four previous editions, Dr. Wechsler's "Textbook of Neurology" has been one of the standard and good books on the subject of clinical neurology. His latest and fifth edition possesses the same good qualities as its predecessors. It presents the subject material in a manner that is concise and based mainly on the author's personal teachings and clinical experience. The passage of four years since the publication of the last edition has witnessed a sufficient number of advances in neurology to justify this new and revised edition. In it one finds that recent advances have been well incorporated and as a modern textbook on clinical neurology this book is therefore well recommended.

WALTER C. WEIGNER, M.D.

RULES GOVERNING THE AWARD OF "THE FOUNDATION PRIZE" OF THE AMERICAN ASSOCIATION OF OBSTETRICIANS, GYNECOLOGISTS AND ABDOMINAL SURGEONS

(1) "The award which shall be known as 'The Foundation Prize' shall consist of $150.00."

(2) "Eligible contestants shall include only (a) interns, residents, or graduate students in Obstetrics, Gynecology or Abdominal Surgery, and (b) physicians (with an M.D. degree) who are actively practicing or teaching Obstetrics, Gynecology or Abdominal surgery."

(3) "Manuscripts must be presented under a nom-de-plume, which shall in no way indicate the author's identity, to the Secretary of the Association together with a sealed envelope bearing the nom-de-plume and containing a card showing the name and address of the contestant."

(4) "Manuscripts must be limited to 5000 words, and must be typewritten in double-spacing on one side of the sheet. Ample margins should be provided. Illustrations should be limited to such as are required for a clear exposition of the thesis."

(5) "The successful thesis shall become the property of the Association, but this provision shall in no way interfere with publication of the communication in the Journal of the Author's choice. Unsuccessful contributions will be returned promptly to their authors."

(6) "Three copies of all manuscripts and illustrations entered in a given year must be in the hands of the Secretary before June 1st."

(7) "The award will be made at the Annual Meetings of the Association, at which time the successful contestant must appear in person to present his contribution as a part of the regular scientific program, in conformity with the rules of the Association. The successful contestant must meet all expenses incident to this presentation."

(8) "The President of the Association shall annually appoint a Committee on Award, which, under its own regulations shall determine the successful contestant and shall inform the Secretary of his name and address at least two weeks before the annual meeting."

JAS. R. BLOSS, M.D., *Secretary.*
418 Eleventh Street, Huntington, W. Va.

MISS MARION WOOD
425 Front Street
Saylesville, R. I.

Can typewrite but no shorthand. Has had experience as receptionist in Out-Patient Clinic.

Desires similar position in doctor's office.

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